COURT OF COMMON PLEAS
CUYAHOGA COUNTY

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NANCY FARKAS,

Plaintiff,

vs. Case No. 393101
Judge McCafferty

CLEVELAND CLINIC FOUNDATION et al.,

Defendants.

- - -

Transcript of videotaped deposition of NATHAN LEVITAN, M.D., Expert Witness herein, called by the Plaintiff as upon cross-examination, pursuant to Notice and Agreement of Counsel, pursuant to the Ohio Rules of Civil Procedure, before Denise C. Winter, a Registered Merit Reporter and Notary Public within and for the State of Ohio on Tuesday, June 20, 2000, at the offices of Reminger & Reminger, 113 St. Clair Building, 7th Floor, Cleveland, Ohio, commencing at 7:00 p.m. and concluding at 9:40 p.m.

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Also present: Randall Buckosh, Litigaide, Inc.
Joanne Sysack

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(See Signature Page)

PROCEEDINGS

NATHAN LEVITAN, M.D.

Expert Witness herein, called by the Plaintiff as upon cross-examination, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION OF NATHAN LEVITAN, M.D.

BY MS. DIXON:

Q. Good afternoon, Dr. Levitan. We met off the record. My name is Debra Dixon. I'm one of the attorneys representing the estate of Nancy Farkas. I'm here today to ask you some questions regarding the materials that you reviewed, the opinions that you rendered in conjunction with the estate of Nancy Farkas versus the Cleveland Clinic Foundation, et al.

Before we get started, let me ask you to state your full name and spell your last name for the record?

A. Dr. Nathan Levitan, L-E-V-I-T-A-N.

Q. And, doctor, have you ever had your deposition taken before?

A. Yes.

Q. And on approximately how many separate occasions?

A. I certainly don't keep records to give you an exact figure. Any number 1 give is going to be a wild guess, but I would guess perhaps eight times in the past, maybe ten.

I'm not certain.

Q. Just to refresh your recollection, all your answers need to be oral. Please refrain from things like nods of the head, hand gestures. If at any point in time you don't understand a question that I have asked, please ask me to rephras'eit or clarify it. If you answer the question, I'll assume that your answer is truthful and accurate.

Finally, if at any point in time you get a phone call, get a page or need a break of any sort, please let me know. I'll be happy to accommodate you. Fair enough?

A. Yes.

Q. I have been provided an updated, what I understand to be an updated copy of your curriculum vitae dated June 5, 2000 and, unfortunately, I didn't have a full opportunity to review that document. The previous CV that I had been provided was, I believe, October of 1998.

Are you able to articulate for me what the changes in your curriculum vitae are from the October '98 to the June 5, 2000?

A. I have had a number of additional publications since that time. That's really the principal difference.

Q. And with the exception of those edits, if you will, or additions, everything else contained on your prior CV is accurate?

A. Correct.

Q. Doctor, currently how would you describe your area of medical specialization and/or concentration?

A. I'm a medical oncologist, though I'm boarded in both hematology and oncology as well as internal medicine. Most of my practice pertains to the whole range of patients with solid tumors, some lymphomas, mainly solid tumors.

Q. I also noted by way of your curriculum vitae there are a number of activities that I would describe, and correct me if I'm wrong or you would use a different term, as administrative-type responsibilities within University Hospital.

A. All of my administrative activities have solely to do with patient care, which is to say that I spend perhaps 10 to 20 percent of my time at the most, some weeks less than that, overseeing quality of care, patient care issues at the cancer center. So all of my administrative activities are directly patient-care orientated.

Q. And would those duties, that description of duties relate to your responsibilities as the medical director of the Ireland Cancer Center Ambulatory Unit?

A. Yes. My role is overseeing the type of patient care that's delivered at our Ireland Cancer Center facilities.

Q. You also indicated by way of your curriculum vitae you're an associate director of the Ireland Cancer Center for clinical programs?

A. Right. These are a variety of titles that essentially all describe the same job.

Q. So although they may have in the sub-branches different titles, wholistically would you describe your primary responsibilities as that of patient care but associated with patient care there may be some collateral administrative responsibilities?

A. Right. I spend most of my time being a doctor and taking care of patients and related to that I take responsibility for issues of quality of care within the cancer center,

Q. And in terms of the patient population that you personally participate in their care, would it be -- do you deal exclusively with patients who have already had their disease diagnosed?

A. No. The role of medical oncologist definitely includes the process of working up an abnormal finding or a suspected abnormal finding leading to a diagnosis and then advising as to how that individual should be treated.

Q. And is there a particular type of patient or a patient with a particular sequelae of symptoms that you would expect to see in your day-to-day patients as it relates to diagnosing their underlying condition?

A. I'm not sure I follow your question.

Q. That was a poorly-worded question probably based on my

search for a pen that worked.

By reviewing your curriculum vitae, it appears as though you have particular interest or specialized interest in the treatment of lung cancer; is that accurate?

A. I have an interest in research pertaining to lung cancer, though my actual patient-care activities are much broader than that.

Q. And would the time that you spend in a clinical setting relate to both the diagnosis and treatment of the patient population presenting with solid tumors?

A. If this answers your question, my time involved in patient care includes the workup and diagnosis and treatment of a whole range of patients with different types of malignancies. They tend not to be patients with leukemia, but they tend to be patients with breast cancer, kidney cancer, lung cancer, esophageal cancer, et cetera.

Q. Do I take it from that answer, you personally had the opportunity to diagnose patients or serve as a primary diagnosing physician for patients presenting with renal cell carcinoma?

A. Correct.

Q. And are you able to quantify for me what portion of your practice consists of patients who are being diagnosed and/or treated for renal cell carcinoma?

A. My practice follows the distribution of cancer within

the population, and we all know that renal cancer is not nearly as common as breast cancer, lung cancer or rectal cancer. I have had many, many countless patients in my years of practice with renal cancer.

At one point when I was practicing in Massachusetts, I was actually running a research protocol pertaining to renal cancer. I had a publication and made a presentation of that work. But I can't give you a specific percentage of patients with renal cancer except to say I have a broad experience in managing those patients.

Q. You indicated that you have at least one publication as it relates to renal cell carcinoma. Is that the publication that is reflected within your CV?

A. Yes.

Q. Are there any other either publications or lectures that you have delivered that relate to the diagnosis and/or treatment of renal cell carcinoma?

A. Not that I can recall.

Q. Doctor, do you recall when it was that you were first contacted by Mr. Kelley and/or any other member of his firm regarding participation in the Nancy Farkas matter?

A. You know, that's not a date that I have written down, so I can't tell you that. 1 could look at the date of my correspondence that I received from Mr. Kelley and that may help to answer your question, and it appears I have a letter

here dated March 31st, 2000, so perhaps I could conclude that it was early this year, but I'm not sure.

Q. And, doctor, is that your file that relates to the Nancy Farkas matter you currently have in front of you?

A. Yes.

Q. I would like the opportunity to take a look at that, please.

Based on your recollection, what were you told regarding the facts of the Nancy Farkas matter?

A. Please repeat your question.

Q. Certainly. Based on your independent recollection as opposed to reviewing any correspondence that's contained in your file, what were you told regarding the underlying facts of the Nancy Farkas matter?

A. So if I understand your question, before I ever received and reviewed the records, your question is, during any phone contact that I might have had with Mr. Kelley, what information by way of introduction did he give me?

Q. Yes. Either Mr. Kelley or a member of his staff.

A. I have absolutely no recollection.

Q. Okay. Do you know how it is that Mr. Kelley came to contact you in this case?

A. No.

Q. Had you ever been requested to review either by way of consultation or ultimately rendering opinions on behalf of a

party in a medical malpractice matter or any other matter for Mr. Kelley?

A. I don't believe that I have ever been asked to review cases in the past by Mr. Kelley.

Q. Have you ever been asked to review cases in the past on behalf of any other lawyer at Reminger and Reminger?

A. Yes.

Q. On how many separate occasions?

A. I don't remember.

Q. Is it more than ten?

A. It may be, but I'm not sure.

Q. Over what period of time have you reviewed these cases for lawyers at Reminger and Reminger?

A. I believe that I have been doing this for about the past three to four years.

Q. Do you recall which lawyers at Reminger and Reminger you have reviewed medical malpractice matters for?

A. I won't remember their names. I recall Mr. Scott. There's an Attorney Malnar for whom I reviewed cases, a Mr. Rymond, and those are the only names that come to mind right now.

Q. As it relates to the Nancy Farkas matter, do you recall by way of that initial telephonic contact what you were requested to do?

A. No. Again, I don't recall the details of that

conversation.

Q. Would review of the documents contained in your file refresh your recollection?

A. Well, I certainly would be glad to read the letter there from Mr. Kelley, however, the details that I recall from this case are really cumulative as I have read additional records, and I really can't go back in time and reformulate an opinion at one point in time.

Q. Do you have an understanding as to what role you are expected to serve or play in the context of this litigation? What I mean by that more specifically is are you prepared to comment as to a standard of care, or are you planing to testify exclusively as it relates to causation issues?

A. I have opinions pertaining both to standard of care and causation issues.

Q. I was provided as I arrived here today one page -- I believe you have the original in front of you -- of handwritten notes. Are those notes that you have prepared or made in conjunction with review of materials in the Nancy Farkas matter?

A. Yes.

Q. And simply to avoid handwriting issues or interpretation issues, can you read for me what's contained on this one page of handwritten notes which we'll mark as Exhibit 1?

A. Sure. On the upper left-hand corner I have "Attorney Kelley." Underneath that "Farkas v. CCF." In the upper right-hand corner, "Dr. Noble, GU, Dr. Mahajan, neurologist, Dr. Ocampo, radiologist, Dr. Thompson, radiation oncologist. Additional records-deposition

Dr. Noble.

10/98, flank pain/hematuria, IVP distal right ureter and right lateral kidney, KUB negative. 11/98, chest x-ray negative, cystoscopy and retrograde negative. 12/98, pelvic echo negative. 8/99, seizure, head CT, multiple lesions, largest ten millimeters, MRI head, multiple five lesions, largest 12 millimeters, chest CT, multiple nodules, largest 14 millimeters plus hilar adenopathy, abdominal CT five centimeters, renal mass. 11/99, Miss Farkas died. Visit, 10/26/98, gave her strainer, review IVP. 11/12/98, culture sent, long discussion with patient and sister (LPN), 11/23/98, cystoscopy and right stent/retrograde. 12/7/98, notes normal pelvic echo, follow-up one month, 1/15/99. Plan stone workup tests. 12/9/98, phone call, delay 24-hour urine until after Christmas. 8/99, sister picks up records."

Q. When would it have been that you prepared the notes which you have just read into the record contained on Exhibit 1?

A. I prepared these notes over the last couple of days.

Q. In anticipation of your deposition here today?
A. Correct.
Q. Would that have been done in conjunction with review of the materials in this case?
A. Correct.
Q. Other than Exhibit 1, are there any other handwritten notes that you have made in conjunction with reviewing your materials?
A. Just the notes I have made along the margin of the stage matrix.
Q. And if I understand your notes to the left of the stage matrix, does that indicate percentage of survivability?
A. Those are predicted five and ten-year survival statistics by stage.
Q. From what source did you derive those predicted survival statistics?
A. Those are based on my knowledge of the general literature and natural history of renal cancer. It's not from a single source.
Q. The notations that you have put to the left of the stage matrix prior to making those notations, did you specifically review any literature or was that all simply done by memory?
A. It was done by memory.

Q. Prior to making the notations that you are referring to -- and for clarification we'll mark this page Exhibit 2 -- When was the last time you had personally reviewed statistics as it related to five and ten-year survivability of renal cell carcinoma?

A. Well, I read a great many medical journals, I spend several hours a week keeping up on the medical literature and I have many files containing those data and I have notes that I take when I read the literature, so this is an accumulation of information, much of which is updated on a regular basis.

Q. And prior to making the notations to the left on the left-hand margin of Exhibit 2, when was the last time you reviewed a medical article -- I'm sorry, a medical journal article that identified or quantified five or ten-year survival statistics in the face of renal cell carcinoma?

A. Given the fact that I probably read 50 articles a week, that's not a statistic that I can give you.

Q. Doctor, I'm going to hand you a copy of your report which I understand you generated on behalf of the Defendants in this case, and I have marked it as Exhibit 3. Is the document marked as Exhibit 3 the only report you generated in this case?

A. Yes.

Q. Were there any drafts of this report?

A. What I do when I write a report is work on the document on the computer and, therefore, rather than there being drafts, I modify the document, and when I come out with a final version -- I'm sure you have generated documents on a computer -- you don't use a draft, you simply modify with a word processing program, so there's no actual draft.

Q. Was there any predecessor report that was generated and forwarded to counsel in this case?

A. I don't believe so; no.

Q. On page 1 of Exhibit 3 you indicate that the documents you reviewed in conjunction with this matter, you noted, number 1, the office records of Dr. Noble; number 2, EMH Regional Medical Center inpatient and emergency records; 3, radiology report from EMH Regional Medical Center; 4, report of Richard J. Hirschman, M.D.; 5, report of Joseph Edward Davis, M.D.

Does that itemization of those five categories of documents identify the totality of information you had available to you at the time you generated your April 4th, 2000 report?

A. Yes.

Q. Do I -- have you been provided any additional information since generating your April 4th, 2000 report?

A. Well, today I received a copy of the deposition of

Dr. Noble, but I have only flipped through this. I have not read it in great detail.

Q. Were you provided any summaries of Dr. Noble's testimony?

A. No.

Q. Have you been provided a copy of Dr. D'Amico's testimony?

A. No. Everything that I have is listed here.

Q. Okay.

MR. KELLEY: Deb, I think the records because they're headed up as Regional -- EMH Regional Medical Center's, but they are all listed in here. He has Dr. Parikh's records, Dr. Stamatis'. He has the Ireland Cancer Center records. They are all in this binder.

BY MS. DIXON:

Q. Are you able to quantify for me approximately how much of Dr. Noble's testimony you have reviewed prior to commencing this deposition?

A. No; I'm not. I flipped through this, but I'm not really prepared to answer questions on this document. I really need to look at it more carefully.

Q. Based on the portions of Dr. Noble's testimony that you have reviewed, is there anything that struck you up until this point that caused you to change any of the opinions that you rendered in your April 4th, 2000 report?

A. Well, item number 3 in this report says, "I do not know whether Dr. Noble intended to perform additional studies to complete the workup for hematuria following the 12/7/98 visit," and just in perusing this, there are a couple of places where he makes it clear that he had a plan in mind to include as part of the workup a CT scan.

So, again, I'd rather not be questioned in detail until I read this thoroughly, but there are a couple of places where he is very clear in saying that, in fact, with careful forethought, he was intending to obtain a CT scan.

Q. Let me make sure you and I are both cn the same page. I appreciate the fact you have only had an opportunity to peruse Dr. Noble's testimony. On page 2, paragraph 3 of your report, the first sentence says, "I do not know whether Dr. Noble intended to perform additional studies to complete the workup for hematuria following the 12/7/98 visit."

And what you're telling me is based on your review of Dr. Noble's testimony, it's now clear to you that he had a more expansive plan in mind?

A. Well, I want to be fair to you. I don't think that it's reasonable to question me in detail on this issue. You know, I could have simply said, well, the report stands, but I'm trying to be entirely forthright and say that I believe that when I review this document carefully, I'll be able to describe to you some of his comments which would lead me to

further clarify paragraph number 3, but I'm not really prepared to go into detailed discussion about that tonight.

Q. Let me ask you a follow-up question regarding sentence 1 of paragraph 3 of your report. Is it fair to say that based on the review of the documents you were provided, separate and apart from Dr. Noble's deposition transcript, your review of those documents left you unable or without information sufficient to determine whether or not Dr. Noble intended to perform any additional studies to complete the workup for hematuria following the 12/7/98 visit?

A. Well, we know that he intended to see the patient again in his office. What we don't know without his deposition is exactly which additional studies he was planning to perform. We do know that he was planning to complete his workup, but I don't know without the deposition exactly what that consisted of.

Q. Doctor, I would ask you to limit your answer to the next question to the records that you were provided at the time you generated your April 4th report. My question is, would you agree that within Dr. Noble's office chart, there is no written suggestion that he had ordered or planned to order a CT scan for Nancy Farkas?

A. I would answer that with the clarification that a follow-up visit was scheduled and we couldn't read his mind to know what he planned to do at that visit. One can infer

that he had a plan for that visit, but specifically to your question, does it say that he planned to do a CT scan at that visit, no.

Q. There's no requisition for a CT scan; correct?

A. Not that I saw.

Q. And the only mention of a CT scan is contained in the provisional and the final IVP report; correct?

A. I don't recall exactly.

Q. Would you agree with me that nowhere in Dr. Noble's office notes as they relate to Nancy Farkas is there any mention of a CT scan? Correct?

A. Being fair, I also have to say that when I saw a dozen patients today and at the end of my note when I indicated return visit, one week or one month, I certainly didn't dictate into my note what I planned to do at those visits.

Q. But that really wasn't my question. My question was, anywhere contained in Dr. Noble's office note is there a suggestion that he planned to perform or order a CT scan?

A. No. He didn't describe what he was planning to do at his future visits.

Q. And, in fact, would you agree there is no plan of care identified anywhere within Dr. Noble's office notes that outlines what he planned to do to rule in or rule out renal cell carcinoma?

A. I think that is fair. Although, again, one has to

bear in mind the purpose of a medical record and what, certainly, what I would or would not put in my records and, as I said, I don't outline what I'm planning to do in the future.

Q. There's no plan of care as it relates to ruling in or ruling out renal cell carcinoma; correct?

MR. KELLEY: Objection. Asked and answered. You can answer again.

A. We know he had a long discussion with the sister at one point. We know he took a lot of time to review the IVP. One would certainly assume that during the lengthy discussions such issues came up. But if you're asking is there in black and white a statement that says I plan to order a CT scan, not that I recall.

Q. And is there anywhere where you reviewed in black and white where Dr. Noble included renal cell carcinoma as part of his differential diagnosis?

A. I don't specifically recall him saying that.

Q. What tests, based on your review of the records you were provided and setting aside for just a moment because you haven't had a full opportunity to review it Dr. Noble's deposition testimony, what tests or studies Dr. Noble ordered or performed to rule in or rule out renal cell carcinoma?

A. It's my understanding that Dr. Noble had a paradigm

that he follows in working up hematuria which includes initially addressing the possibility of stones and as part of that workup, after doing the metabolic testing involved in that, he would obtain a CT scan.

And I understand that this is the pattern that he generally follows as a urologist in doing this kind of workup and that a CT scan was planned to simultaneously look for other stones and follow up on the finding that appeared abnormal or possibly abnormal within the kidney on the additional IVP.

Q. Would you agree with me that the explanation you have just provided to me is contained in Dr. Noble's deposition transcript as opposed to contained within the four corners of the medical record?

A. Yes; I would.

Q. Would you likewise agree with me that within the four corners of Dr. Noble's record as it relates to Nancy Farkas, there is not a single diagnostic study that he ordered that was useful in ruling in or ruling out renal cell carcinoma?

A. Well, the initial IVP certainly is a study that can be useful in that regard.

Q. That wasn't ordered by Dr. Noble; correct?

A. Correct. But he had that available to him.

Q. Other than the IVP which Dr. Noble did not order, are there any studies you saw based on your review of the record

that were ordered by Dr. Noble which would be useful in ruling in or ruling out renal cell carcinoma?

A. No. I believe that those were tests that he did not have an opportunity to order because the patient did not follow up with him.

Q. And that understanding that you have based on him, Dr. Noble, not having the opportunity to order those tests is based on his deposition testimony as opposed to the medical record?

A. Well, not entirely, because the medical record does show that he intended to see the patient in follow-up I believe in January, if I look at my notes, and that she failed to keep that appointment January 15th.

Q. Doctor, have you ever spoken or lectured to attorneys who defend medical providers in negligence claims?

A. Please ask me that question again.

Q. Certainly. Have you ever spoken in a group format or lectured to attorneys who defend medical providers in negligence claims?

A. When I first moved to Cleveland back in 1991, an attorney by the name of Steve Walters asked me to lecture to a group of attorneys on the topic of breast cancer. At that point I had absolutely no exposure to this kind of work and I'm not sure what the specialty of those physicians was. In retrospect, perhaps there were some physicians involved in

medical malpractice.

Q. You indicated by one of your prior answers you have participated in medicolegal issues in the past; correct?

A. Correct.

Q. On any of those occasions have you ever rendered opinions on behalf of the plaintiff?

A. Yes.

Q. And how would you quantity your participation as it relates to plaintiff versus defendant?

A. I would guess that among the cases I have reviewed, about 20 percent of them are cases in which I am asked to assist by the attorney for the plaintiff. If you ask in terms of appearances in court, I have only been to court once and that happened to be a few weeks ago and I was working for the plaintiff.

Q. And what attorney represented the plaintiff in that case?

A. This was a case in Dayton, Ohio.

Q. What was the name of the attorney?

A. It will come to me. I'm not remembering right now.

Q. If you recall, please let me know.

I appreciate the fact you have only skimmed Dr. Noble's deposition transcript. Have you had an opportunity to speak with him either in person or by telephone regarding this case?

A. No.
Q. Have you had an opportunity to speak to Dr. D'Amico by telephone or in person regarding this case?
A. No.
Q. Were there any opinions you were requested to render in this case which you were unable to or uncomfortable providing?
A. No.
Q. Have you spoken with Dr. Flanagan?
A. No.
Q. Do you know Dr. Mark Thompson?
A. Yes.
Q. And are you aware of the fact Dr. Thompson participated in the care of Nancy Farkas?
A. Yes.
Q. Have you spoken to Dr. Thompson regarding this case?
A. Absolutely not.
Q. Is Dr. Thompson a physician whom you respect his professional capabilities as a physician?
A. Yes.
Q. And is my understanding correct that Dr. Thompson is associated with the Ireland Cancer Center as a radiation oncologist?
A. Correct.
Q. And that he is also board certified in hospice and

palliative medicine?
A. I believe that that is the case. I'm not familiar with the details of his CV, but I know that he certainly has training in those areas.
Q. As it relates to Dr. Thompson's abilities as a radiation oncologist, first of all, have you had an opportunity to work in conjunction with Dr. Thompson professional to professional?
A. No. He has been with us for, I believe, somewhat less than a year and he works mainly out of our Westlake Ireland Cancer Center facility and I don't care for patients there.
Q. In the event that you came in contact with a patient who the Westlake facility of the Ireland Cancer Center was more convenient, for example, would you have any hesitation referring that patient to or recommending that that patient be treated by Dr. Thompson?
A. No.
Q. Would you be comfortable, in the unfortunate event you needed it, permitting one of your family members or friends to be treated by Dr. Thompson?
A. Yes.
Q. Why?
A. Perhaps I misunderstood your question. Would I be comfortable or uncomfortable.
Q. I said in the unfortunate event the need arose, would

you be comfortable permitting Dr. Thompson to render care to one of your family members or friends?

A. The answer is yes.

Q. You indicated earlier that you participate not only in the diagnosis but the eventual treatment of patients who present with renal cell carcinoma; correct?

A. Correct.

Q. As part of your standard protocol both in diagnosing and treating patients who may be presumptively diagnosed with renal cell, do you outline a treatment plan for that patient?

A. I'm not sure I understand your question.

Q. That's fair. I'm assuming, based on the description you provided me of your practice, that you see patients in various stages, not only the stages of disease but also those who have been diagnosed and those who have yet to be diagnosed; correct?

A. Correct.

Q. And you indicated earlier that the renal cell carcinoma population is a patient population that you have contact with; correct?

A. Correct.

Q. My question is, in the process of diagnosing a patient who may be presumed to have renal cell carcinoma, do you personally -- that was poorly phrased -- is it your personal

protocol to formulate a treatment plan?

A. Well, see, I'm not sure what you're asking.

Q. You have a patient that presents to your office whom you presume has renal cell carcinoma or you are suspicious has renal cell carcinoma. As part of your evaluation of that patient, do you formulate a treatment plan to assist you in ruling in or ruling out that condition?

MR. KELLEY: Objection. You can answer.

A. I always have in my mind an idea of where I'm going in managing a patient, if that's your question.

Q. And as it relates to ruling in or ruling out renal cell carcinoma, is there, for lack of a better term, a standardized protocol you follow to ultimately diagnose that patient's condition?

A. No. I would individualize it depending upon the situation.

Q. I believe you indicated in one of your previous answers you have been in the greater Cleveland area since 1991; correct?

A. Correct.

Q. And would you agree with me as it relates to northeastern Ohio, a CT scan is a readily available diagnostic tool?

A. Yes.

Q. And it is reasonably accessible for physicians within the northeastern Ohio area; correct?
A. Correct.
Q. And I'm assuming in the course of your practice, you have more than ample opportunity to utilize CT scans within University Hospitals; correct?
A. Correct.
Q. And do you have a generalized knowledge of the availability of that diagnostic tool at other facilities?
A. Correct.
Q. Are you aware of whether or not Elyria Memorial Hospital has CT scanning facilities?
A. Most hospitals these days have such equipment.
Q. And in your experience of having the need present itself to you and requisitioning and ultimately obtaining a CT scan for a patient, what, on average, would you tell me your turnaround time is from identifying the need to obtaining the test?
MR. KELLEY: Objection.
MS. PETRELLO: Objection. Are you talking about in the office or what kind of a setting?
A. In our institution, there can sometimes be a two or three-week delay depending upon the type of scan and how busy the unit is. Seldom more than that.
Q. Would you agree with me that in the event the CT

scanning facilities within your hospital are heavily booked with outpatient scans, that you have the ability to indicate some urgency in requesting that test?

A. Correct, if it's clinically indicated.

Q. Based on your review of Miss Farkas' medical records, are you familiar with the fact that in August of 1999 there was a core biopsy of her kidney?

A. Yes.

Q. And you're likewise familiar with the fact that that specimen was evaluated by a pathologist?

A. Yes.

Q. And are you familiar with what the conclusions of the pathologist were regarding that core biopsy?

A. I believe it was called a renal carcinoma clear cell type.

Q. Do you agree with the statement that a nuclear grade 3 renal cell carcinoma is an aggressive cancer?

A. I think that when one talks about aggressive or non-aggressive, I think that's a vague statement.

Q. In the context of treating or evaluating and treating patients with cancer, is part of your role determining the aggressiveness of their disease?

A. I don't follow your question.

MR. KELLEY: Object to "aggressiveness."

BY MS. DIXON:

Q. Doctor, are you aware of medical literature that identifies nuclear grade 3 renal cell carcinomas as, "aggressive cancer"?

A. I wouldn't use the term "aggressive." I think it's fairly ambiguous. It doesn't mean much to me.

Q. Would you agree that early diagnosis in cancer is Paramount to effective treatment?

MR. KELLEY: Objection to generalities. You can answer.

A. In what situation?

Q. Is there ever a situation where early diagnosis of cancer is not to the patient's benefit?

A. Well, I would explain it this way: Theoretically speaking, if one can find a cancer when it is truly, I don't mean clinically but I mean truly, localized and remove it before metastatic disease has occurred, that is before microscopic tumor cells escaped, then an earlier diagnosis does, in fact, favorably impact outcome, absolutely.

Breast cancer is a good example of that. If you can find a breast cancer when it's non-invasive or minimally invasive, if you can detect a cervical cancer when it's in situ rather than invasive, this has major impact on outcome.

The reason your question is potentially misleading, to take the example of lung cancer, it's been well shown that

screening for lung cancer doesn't have any impact on survival because by the time a nodule is big enough to show up on chest x-ray, if it's going to metastasize, it's already done it, so an earlier diagnosis of that nodule has really no impact on that patient's ultimate outcome.

Q. Is there any relationship in the area of renal cell carcinoma between early detection -- excuse me, early diagnosis and ultimate patient outcome?

MR. KELLEY: Objection. You can answer.

A. It depends on the particular situation involved, but it's simplistic and potentially misleading to say that in all cases of renal cancer a diagnosis X number of months earlier would, in fact, alter that patient's outcome.

Q. My question is, is there any prognostic value -- let me rephrase that.

Is it your testimony that there is no appreciable or quantifiable benefit to early diagnosis of renal cell carcinoma as to the patient's ultimate outcome?

A. It depends on the clinical situation.

Q. You state on page 2 of your report at paragraph 4, "It is well known that renal'' cell -- I'm sorry, "renal cancer is an extremely slow growing cancer (especially clear cell type)'' --

A. Excuse me. Where are you?

Q. Page 2, paragraph 4. "-- and that most renal" cell -- "most renal cancers are many years old at the time of diagnosis."

Is it your testimony that all renal cancer are "extremely slow growing cancer"?

A. Well, I would have to clarify the term "slow growing," just as I requested clarification when you talked about the word "aggressive," and I would use as an example the fact that a one centimeter tumor which is generally at the lower limit of detectability on a CT scan has about a billion cells, and even though discussing double times can open a whole discussion that we may or may not choose to get into, conceptually double times are useful and they tell us how quickly a given tumor is likely to proliferate.

We know this, a renal cancer in general, has relatively long double time, something in the range of 80 to 90 days, possibly longer, which means that a one centimeter renal cancer is many years old at the time of diagnosis. The other feature of renal cancer is that the characteristics of the natural history of this disease is that microscopic metastases tend to occur early and can be undetectable and may not manifest themselves until long after the initial diagnosis.

Q. Are you able to describe for me the doubling characteristics or features of the nuclear grade 3 clear

cell renal carcinoma?

A. You can't assign a particular double time based on whether a tumor is a nuclear grade 3 or nuclear grade 2, but regardless of the nuclear grade, these are tumors that grow over a period of many years.

Q. Do you have any dispute as you reviewed Miss Farkas' medical records that her right kidney was the primary tumor site of her cancer?

A. I believe that the right kidney was the primary site for cancer.

Q. And as a general rule, would you agree that kidneys -- a kidney is generally a primary tumor site as opposed to a location of distant metastases?

A. Well, it depends upon the tumor. Metastatic disease to the kidney can certainly occur, but in this case, I believe that her kidney was the primary site.

Q. Would it be fair to say that in October of 1998, after Nancy's IVP, that the diagnosis of cancer was there to be made but simply wasn't?

A. Well, I'm not sure what you mean by that.

Q. Is there any doubt in your mind, based on review of Nancy's medical records and your education, training and experience, that she did, in fact, have renal cell carcinoma on October 20th of 1998?

A. I believe that she had renal cancer in October of

1998. I believe it had already metastasized in October of 1998.

Q. And what is your basis for concluding that in October of 1998 Nancy had metastases?

A. Well, we know that in August of 1999 she was full of cancer. She had multiple lesions in her brain. She had multiple lesions in her lungs. She had enlarged lymph nodes in the hilar region related to her cancer. She had lost something like 35 pounds. She had a 5 centimeter renal mass. In terms of what we call tumor burden, this is an enormous amount of tumor, knowing that in order to grow to 1 centimeter in size, a tumor has to be generally 5 to 6 years old. There's no way.

MS. PETRELLO: How many years?

THE WITNESS: 5 to 6 years old.

MS. PETRELLO: Thank you.

A. There's no way in the world that all of this extensive metastatic disease could have entirely popped up in 2 or 4 or even 6 months.

Q. Is it possible for a patient with a stage I renal cell carcinoma to have metastatic disease?

MR. KELLEY: I'm going to object. For them to have a stage I?

MS. DIXON: Stage I tumor and metastatic disease.

MR. KELLEY: From a stage I tumor?

MS. DIXON: Yes.

A. Here's how I would answer your question: When one talks about staging, one has to be very clear whether one is talking about clinical staging or what is actually present if you could get inside the body and look. If you look at the five and ten-year survival statistics for a patient with a stage I kidney cancer, you see that five-year survival is 65 percent give or take a few percent.

Q. And, again, just so we're clear, this is your constellation of statistics from the variety of sources you have access to?

A. Yes. And I would have no trouble if you would like me to provide an array of textbooks with numbers that are give or take a few percent in this ballpark. This is mainstream. This is not anything unusual that I'm presenting here.

Back to my point, a patient with a stage I renal cancer has a predicted five-year survival of about 65 percent. Why, if it's small, stage I, localized, removed, do 35 percent of those people die within five years? They die because all of those people have microscopic tumor cells that have departed long before diagnosis of this apparently curable stage I cancer.

What happens at ten years, nearly half of those people are dead, and, again, you have already taken out that small

apparently stage I cancer maybe nine years ago. It means those microscopic tumor cells departed long before diagnosis and were sitting there.

So to answer your question, a patient with a stage I cancer has a very strong likelihood that there's metastatic disease, but we don't call that stage IV because we can't find it.

Q. With that answer as a backdrop, doctor, as it relates to this concept of micrometastases that you just alluded to in stage I renal cell carcinoma, of the 65 percent of patients treated who survive for five years, do any of those patients, based on your experience, have micrometastases?

A. Yes, because some of those go on to die by ten years.

Q. But the mere fact that a patient might have micrometastases at stage I does not preclude five-year survival; correct?

A. Correct.

Q. And, likewise, the fact that a patient diagnosed at stage I with renal cell carcinoma and micrometastases does not preclude a ten-year survival; correct?

A. Well --

Q. Because you have given me the statistics of 55 percent survive ten years when diagnosed at stage I; correct?

MR. KELLEY: 55 or 35? I can't read that.

THE WITNESS: That's 55.

A. Please ask me that question once more.

Q. Certainly. We have already talked about the fact out of the entire patient population that are diagnosed stage I renal cell carcinoma, 35 percent do not survive five years; correct?

A. Correct.

MR. KELLEY: Objection.

BY MS. DIXON:

Q. My follow-up question was, of the 65 percent that do survive five years, you have already agreed with me some percentage of those patients likewise have micrometastases; correct?

A. Correct.

Q. So my question becomes, wouldn't you agree that the fact that a patient stage I who has micrometastases does not preclude them from surviving for five years?

MR. KELLEY: Objection.

A. Well, if you're drawing analogy and this is where you're going to Mrs. Farkas --

Q. Let me be clear, doctor. I'm not asking you about Nancy Farkas right now. You have drawn my attention to this matrix contained on Exhibit 2.

A. Okay.

Q. And we have -- you have identified for me plus or

minus whatever those percentages might be based on the various sources you drew from at stage I diagnosed and treated at stage I, there is a 65 percent five-year survival rate; correct?

A. Correct.

Q. And you have already agreed with me that of that 65 percent that survive for five years, there are at least some percentage of those patients that have micrometastases?

A. Correct.

Q. And what I have asked you now is, based on the fact that of the 65 percent that survive five years with micrometastases, wouldn't you agree that the mere fact that a patient has micrometastases at stage I does not preclude their five-year survival?

A. That is correct because those metastases can become active at a variety of different points in time. They can become active one year after diagnosis, one month after diagnosis or ten years after diagnosis.

Q. And, likewise, as it relates to diagnosis and treatment at stage 11, some percentage of those, of the 50 percent of patients that survive five years do have micrometastases at the time of diagnosis; correct?

MR. KELLEY: Objection. You keep leaving out whether you clarified clinical staging versus absolute stage.

BY MS. DIXON:

Q. That brings up a good point, doctor. This matrix that you are referring to, is this based on clinical or pathological staging?

A. This is based on, in general, it's based on the staging after a patient has had his or her kidney removed for an early stage tumor. For a patient with metastatic disease, in most cases this is variable. A nephrectomy is not done, so this is really a combination of surgical and radiologic staging.

Q. I just need to make sure you and I are on the same page. The staging that's contained on Exhibit 2, that relates -- that represents a constellation of both pathological stages as well as clinical staging?

A. Correct.

Q. Okay. So my question becomes, based on the chart contained in Exhibit 2, a patient diagnosed and treated with stage II renal cell carcinoma, using your numbers, has a 50 percent chance -- I'm sorry, has a 50 percent five-year survival; correct?

A. Correct.

Q. And you would agree with me out of those 50 percent of the patients that survive five years, some percentage of those patients at the time of diagnosis had micrometastases; correct?

A. Correct.
Q. And despite the micrometastases which they had at the time of diagnosis, stage 11, they nonetheless survived five years; correct?
A. Well, that's potentially misleading, though, because if you look at the difference between the five and ten-year survivals, they're 10 percent, 15 percent for stage I and 11, relatively small, which is to say that most people with metastatic disease at the time of diagnosis are going to die pretty fast.
Q. My question relates to five-year survival statistics. You told me it's 50 percent at stage 11; correct?
A. Correct.
Q. And you have agreed with me that of the 50 percent of patients diagnosed at stage II that survive five years, some percentage of those patients at the time of diagnosis had micrometastases; correct?
A. Correct.
Q. And would you agree with me based on current standards within the realm of diagnosing and treating patients with renal cell carcinoma, survival is measured based on a five-year window?
A. One looks at both five and ten-year windows.
Q. Would you agree with me there is by far more literature evaluating five-year survival statistics in renal

cell carcinoma than ten-years statistics?

MR. KELLEY: Objection.

A. Not necessarily.

Q. In the course of your work as a medical oncologist, I'm assuming you deal with patients with brain metastases on a fairly regular basis.

A. Correct.

Q. And in your experience, for what period of time are patients with brain metastases asymptomatic? And I'm discussing absent treatment.

A. Well, they can be asymptomatic during the period of time that these microscopic tumor cells are growing. A single tumor cell that arrived in the brain through the bloodstream has to grow a very long time until it is large enough to cause symptoms or to be visible on MRI scan.

So if you're asking how long is it from that very first metastatic cell until the patient has golf-ball size lesions visible on MRI scans and seizures, it can be years.

MR. KELLEY: Can we take a quick restroom break?

MS. DIXON: Sure. No problem.

(Thereupon, a recess was taken.)

MS. DIXON: Back on.

THE VIDEOGRAPHER: We're back on.

BY MS. DIXON:

Q. Doctor, before we took a short break, we were talking a little bit about brain metastases. Would you agree that brain -- metastases of the brain grows at different rates in different patients?

A. There certainly is variability, however, there is a range of rates at which cancers grow, and, for instance, for most solid tumors, excluding certain high grade lymphomas and small cell lung cancer, cancers grow slowly over a period of years, and even those there's variability. They just don't come up overnight.

Q. It is your opinion, if I understand it correctly, that in October of 1998, Nancy Farkas had micrometastases in the brain?

A. Correct.

Q. And upon what clinically do you base that conclusion?

A. Well, I believe that I have answered that question, but I would be glad to review that answer with you.

Q. Let me rephrase the question. Is there anything based on Nancy's clinical presentation in October of 1998 that supports your contention she had brain micrometastases?

A. No. We know that based on her subsequent course.

Q. Are you familiar with a concept known as spontaneous regression?

A. Yes.

Q. And would you agree with me that that describes a

situation where the primary tumor burden is removed and the cancer regresses?

A. People have been talking about that in renal cancer. It's an old concept. It still hangs around, but it basically is rare as hens' teeth, and everyone brings it up when they think of renal cancer. But as I teach fellows and residents when I'm at work, it is not something that we see except under extraordinarily rare circumstances. It is not part of the usual natural history of this disease.

Q. But it is a real and a documented medical event; correct?

A. But it is unreasonable and incorrect to invoke that as a reason to take out a primary lesion. In fact, it is the wrong thing to do to take out a kidney in the presence of metastatic disease by saying, well, we hope that it will cause spontaneous regression.

Q. Dr. Levitan, is it your position that had Nancy Farkas' renal cell carcinoma been diagnosed in October or November of 1998, that she would still not be with us today?

MR. KELLEY: I object to the double negatives.

A. Please ask that again.

Q. You're aware of the fact that Nancy Farkas died in November of 1999; correct?

A. Correct.

Q. And your position, as I understand it, is even with diagnosis in October or November of 1998, she had brain metastases and ultimately would have succumbed to that?

A. Correct.

Q. My question is, had Nancy's cancer been diagnosed and treated in October or November of 1998, would she have been alive today?

A. No.

Q. And upon what do you base your conclusion that Nancy Farkas with diagnosis and appropriate treatment in October or November of 1998 would be dead today?

A. Well, we know per our discussion a few minutes ago that she already had microscopic metastatic disease in October of 1998, therefore, if one had taken out the kidney, one would have left behind all of that microscopic metastatic disease which by that time had taken on a life of its own and it would have begun to manifest itself in the form of seizures in August of 1999.

She would still have had her pulmonary lesions seen on CT scan, she would still have had abnormal MRI of the brain and she would still have died in November of 1999, and in retrospect, would have had an unnecessary operation in October of 1998.

Q. Is it your testimony that had you evaluated, diagnosed and outlined treatment for Nancy Farkas in October of 1998,

you would not have recommended a nephrectomy?
A. I don't believe I said that.
Q. I'm asking.
A. So your question is?
Q. Well, you indicated in your previous answer that Nancy would have gone through a needless surgery.
A. In retrospect.
Q. My question to you is, if Nancy Farkas had come to you in October of 1998 for diagnosis and treatment, would you have recommended a nephrectomy?
A. Yes.
Q. And is the reason that you would have recommended a nephrectomy in October or November of 1998 because a nephrectomy offered the patient such as Nancy Farkas the best opportunity to do well?
A. Well, once a diagnosis of renal cancer had been made, whether that was October '98 or sometime in the next few months thereafter, one would have done a metastatic workup and if that metastatic workup had been negative, then it would have been appropriate to take out the kidney.

That particular procedure would only have been beneficial for her if, in fact, she did not have microscopic metastatic disease that had already spread. Noting that our diagnostic tools aren't good enough to detect microscopic metastatic disease, we go ahead and take out the kidney, but

if we could look in retrospect, those people who already have the metastatic disease don't actually benefit from that procedure. It doesn't mean it's the wrong thing to do. It just means they don't benefit from it.

Q. But you did indicate in one of your previous answers that in patients who are diagnosed and treated at stage I have a 65 percent five-year survivability, correct?

A. Correct.

Q. And of that 65 percent, some percentage of those that do survive, some percentage of those patients at the time of diagnosis and treatment have micrometastatic disease?

A. Whether or not they survive has nothing to do with whether or not their kidney is taken out if they already had metastatic disease.

Q. You seem to have indicated in one of your previous answers that the success of the nephrectomy is relative to whether or not the patient is diagnosed -- at the time the patient is diagnosed there's metastatic disease.

A. Correct.

Q. And my question to you then becomes, what percentage of the 65 percent of patients diagnosed and treated at stage I renal cell carcinoma that survive five years have metastatic disease at the time of diagnosis?

A. You're confusing me. If we look at the five -- and I'll try to answer your question. If we look at the five

and ten-year survival statistics for a patient with stage I cancer, as I said, most of these people who have metastatic disease are going to die relatively quickly. There are some in whom that metastatic disease will sit around for a long time before declaring itself.

By ten years, most people who have microscopic metastatic disease will have manifested so that if we look at the 55 percent who are alive at ten years of the original group of patients with stage I cancer, those patients are pretty much free of microscopic metastatic disease, acknowledging that occasionally at 15 years a renal cancer will develop a brain metastases, but that's the exception rather than the rule.

Q. Are you able to state with any degree of medical certainty what percentage of the 65 percent of renal cell carcinoma patients diagnosed at stage I that survive five years also have micrometastases at the point of diagnosis?

A. Well, I would answer that by looking at the ten-year rate. In other words, if we, as I said, let's assume for purposes of discussion that at ten years, if you lived without evidence of metastatic disease, you probably don't have any, acknowledging that there are a few who will pop up later, but for all intents and purposes, if you are okay at ten years, you're probably free of microscopic metastatic disease.

The spread between the five and ten-year survival statistics is ten years, so you look at the 65 percent of patients. That group of patients who have lived five years and are disease free, about another 10 percent of the original group will demonstrate metastatic disease in the subsequent 10 years. The rest are free of microscopic disease.

Q. Is the short answer, doctor, that of the 65 percent of patients that survive five years with a diagnosis and appropriate treatment of a stage I renal cell carcinoma, you are not able to state with any degree of medical certainty what subset of that 65 percent have microscopic metastatic disease?

MR. KELLEY: Objection. I think he just answered that.

A. No. I think I have given you what I hope was a very comprehensive answer to that question.

Q. Is the only indicia you have as to what percentage present with micrometastases based on the ten-year survival rate?

A. I don't understand your question.

Q. Are you using the ten-year survival rate to retrospectively evaluate what percentage of the five-year survivors have metastatic disease at the point of diagnosis?

A. I think we're getting very confused with percentages

of percentages of percentages here. Let me try to explain this once more. Okay?

Let's start with 100 patients. Let's start with 100 patients who have stage I renal cancer at the time of diagnosis. At five years, 65 of those patients will be alive, 35 will be dead. Some of those 65 patients still have metastatic disease that may not have manifested itself at that point. I'm not even going into the whole discussion of the difference between disease-free survival and overall survival. Let's just not go there for now.

So of that original 65 patients, another 10 will demonstrate evidence of metastatic disease by the end of 10 years leaving us with 55, and those 55 are probably free of metastatic disease, though a couple may fail late. That's as clear as I can be.

Q. In October of 1998, do you know what stage Nancy Farkas' renal cell carcinoma was clinically?

A. No.

Q. Based on the records you have in front of you, are you able to draw any conclusions to a reasonable degree of certainty as to what clinical stage that renal cell carcinoma was in October of '98?

A. No. She would have had to have CT scans of the chest and abdomen, brain before one could make that determination.

Q. Put another way, would you agree that the reason you

are not able to conclude as you sit here today what stage Nancy's cancer was in October of '98 is because she simply did not have the tests that would permit you to make that conclusion?

MR. KELLEY: I only object because you took the word "clinically" again out of your question and he's been answering clinically. I don't want to have a misrepresentative record.

BY MS. DIXON:

Q. That was a late-in-the-evening oversight, not an attempt to mislead you.

A. So tell me your question once more.

Q. My question is, would it be fair to say that the reason that you are not able to determine the stage of Nancy's renal cell carcinoma from a clinical perspective in October of 1998 is because the tests were not performed that would give you the information you need to draw that conclusion?

A. Correct.

Q. By the way, have you ever seen any of the films that were taken on October 20th of 1998?

A. I don't think so.

Q. Did you rely exclusively on the narrative radiology reports that were provided in Miss Farkas' medical record?

A. Yes. I looked at a lot of x-rays, but if I'm not

mistaken, I don't think that you sent me the films on this. I just read the records.

Q. Doctor, as an oncologist, do you agree with the concept that a patient diagnosed with cancer must be given the best opportunity to do well?

A. I think it would be hard to argue with that statement.

Q. And would you agree with me that a physician treating a patient with cancer must present that patient with the best opportunity to do well?

A. Again, it's hard to argue with that statement.

Q. Would you likewise agree with me that early diagnosis is critical in providing a patient with the best opportunity to do well?

MR. KELLEY: Objection. Asked and answered.

A. I think we discussed that at some length before.

Q. Is the answer yes or no?

MR. KELLEY: Objection. He does not have to answer it yes or no. He can stand on his answer or recite his answer if you want him to.

A. I think we had a lengthy discussion about the natural histories of different types of cancers and situations in which early diagnosis affects the natural history and situations in which it doesn't, and I could do that again, we could read the transcript or however you would like to do

it.

Q. You indicated in your report of April 4th of 2000 that you reviewed the reports of Dr. Davis and Dr. Hirschman; correct?

A. Correct.

Q. And in conjunction with reviewing those reports, and you can feel free to take them one at time, are there any specific criticisms that you have of -- let's start with Dr. Davis' report?

A. Well, they're not fresh in my mind, but if you don't mind waiting, I'll read over the report.

Q. I'd be happy to.

MR. KELLEY: Can we go off the record while he does it?

MS. DIXON: Sure.

(Thereupon, a brief recess was taken.)

MS. DIXON: Back on.

A. I disagree with many points, and if you would like to take the time, we can go through this.

Q. You have now had an opportunity to review Dr. Davis' report dated February 18th, 2000; correct?

A. Correct.

Q. And you have some criticisms and/or comments or just professional disagreements in the conclusions that he's drawn; correct?

A. Correct.
Q. And can you go through the report and let's do it paragraph by paragraph and tell me what criticisms or disagreements you have with Dr. Davis' opinions.
A. He says, "In my opinion with medical certainty that the cyst of the kidney on its lateral border seen on the IVP should have been evaluated by a sonogram and CT scan at the time of the patient's presentation to the emergency room on October 20th, 1998."
I see no reason why those studies should have been done exactly on that day, and in my experience in most places, they wouldn't have been.
Q. Let me ask you a follow-up question to that, doctor. Is there a time frame in which you would expect a sonogram or a CT scan to be done as a follow-up to the emergency room IVP as it relates to Nancy Farkas?
A. Well, in this particular situation, it was -- there was evidence of stone and there was also another lesion of uncertain significance, and it is my understanding that over a period of about 90 days, there was a plan to complete the workup which included a CT scan, and given the natural history of this disease, that is not an unreasonable duration over which to complete a workup of this type.
Q. Is there an outside limit which you would consider acceptable between the date of the IVP and obtaining either

a sonogram or a CT scan to further evaluate the cyst or mass?

MR. KELLEY: We're assuming she doesn't require surgical intervention for the stone or the obstruction?

MS. DIXON: Correct.

A. Right. I think over a period of a few months, a workup like this should be complete.

Q. How are you quantifying "a few months"?

A. I'm not going to give you a precise rigid number except to say that given how slowly cancers grow, for a workup to proceed over a period of two or three or even four months is not unreasonable.

For example, a woman with a breast lump may go for a second and third opinion and may end up delaying the surgery on that lump three months. It's not unusual. In my experience, that doesn't alter her ultimate outcome. Similarly, a workup like this proceeding in a step-wise fashion over a period of two or three months or so doesn't alter the patient's outcome.

Q. Okay. In the third paragraph of Dr. Davis' report, is there anything else you have a disagreement with?

A. He says, "It is also my opinion that these studies would have demonstrated findings consistent with renal cell carcinoma. Had the appropriate diagnostic workup been

completed at that time with partial or complete nephrectomy, the five-year survival rate would have been better than 60 percent."

I disagree with that for reasons that we have discussed at great length tonight.

Q. And that's based on the micrometastases that you assumed was present in October of 1998?

A. Correct. And we don't know whether perhaps even more than micrometastases were present at that time had other tests been done.

Q. Moving on, is there anything else in that paragraph? Excuse me.

A. No.

Q. What about the next paragraph?

A. "It is probable that the apparent renal colic of October 20th, 1998 was due to the passage of a blood clot rather than a stone as a result of the tumor."

I don't know how in the world one could reach that conclusion. There was evidence of both nephrolithiasis and this other questionable finding in the kidney. I don't think one can tell what the pain was from.

"It is my opinion that the tumor had affected the collecting system of the patient at the episode of the renal colic. Although the mass itself was in an area far from the collecting system bleeding can be a sign of tumor."

This is all conjecture as far as I'm concerned. I do believe that in retrospect the bleeding was related to the tumor, that is to say the microscopic bleeding was related to the tumor, possibly the stone, as well. I don't think we really know that, but I don't think we can by any means identify where this tumor is relative to the collecting system.

Q. But, again, you haven't reviewed the films; correct?

A. Correct. But he does say, "Based on the IVP, it is not possible to tell, however, whether or not the lesion had reached the fat around the kidney or was still within the capsule at the time of the original IVP."

Q. Do you disagree with his statement that the reason that information is not available is because the appropriate studies were not done to diagnose that condition?

A. Well, the word "appropriate" is somewhat judgmental. I would say that additional studies might have clarified that were not done at that time.

Q. You don't dispute the fact that the appropriate -- let me ask the question a little bit differently. In your practice, in the face of a suspicious IVP, and I mean a suspicion in terms of concerns of a renal cell carcinoma, would you utilize a sonogram or a CT scan to further evaluate that patient?

A. Yes. Over the course of a workup. As we know here,

this was a more complicated situation. There was plan to do that, but it was step-wise progression.

Q. And would you likewise agree with me that the diagnostic studies that were performed on Nancy Farkas by Dr. Noble between October 26th and, I'm sorry, December 7th of 1998, none of those diagnostic tools were of benefit in further evaluating the cyst or mass identified on the October 20th IVP?

A. The cystoscopy and retrograde done on 11/23 could conceivably have been, but as it turned out, it wasn't.

Q. That diagnostic tool did not provide Dr. Noble with any additional information regarding the cyst or mass of the 10/20/98 IVP; correct?

A. Well, unless the absence of demonstrating it can be considered information, which I think it probably can, but it did not demonstrate the mass.

Q. Okay. *Any* other criticisms of Dr. Davis' opinions?

A. Well, this is more of the same. He says on page 2, "Thus a proper evaluation of the IVP being performed when the patient was first seen on 10/20/98, then a reasonable sonogram or CT would have been ordered.''

It's, again, the same issue of making a judgment with which I don't agree. Likewise, his comment about the deviation from the standard of care I don't agree with.

Now, in the next paragraph, he says -- more discussion

about whether or not a CT should have been done as we have discussed. "The normal laboratory studies and chest x-ray of November 1st did mean that the tumor had not metastasized to the chest at that time." Well, that's a preposterous statement because the chest x-ray is the crudest of tools and by no means tells us whether or not metastatic disease has occurred. "The pelvic ultrasound ordered by Dr. Noble had no relevance to the diagnostics or evaluation." That's true.

.He says, "This is a tumor that undoubtedly spread and grew larger from October 20th, 1998 until early August 1999." If he's implying that the actual initial metastasis of microscopic cells occurred during that interval, that is impossible based on the natural history of this disease. And, likewise, I disagree with the final paragraph as we have discussed.

Q. Okay. Now, you, likewise, you have in front of you a copy of Dr. Hirschman's report; correct?

A. Correct.

Q. Why don't you take a moment and review that report and let's talk about the criticisms you have of Dr. Hirschman's opinions.

A. Okay. In the last paragraph, he says, "With a reasonable degree of medical probability, it can be stated that had the diagnosis of renal carcinoma been made in

October 1998, the stage would have been I or II with a greater than 50 percent chance of survival for five years if appropriate surgery had been performed at that time."

Well, as we have discussed, we don't know what the clinical stage would have been at that time, but whatever the clinical stage would have been, the subsequent course of her illness and ultimate death would have taken place regardless, so that intervention would not have altered her outcome. In August 1999 when the diagnosis was stage IV renal carcinoma, the chance for survival five years was less than ten percent and she did, indeed, succumb in three months. Those are my comments.

Q. Does that conclude your criticisms regarding both Dr. Davis' and Dr. Hirschman's reports?

A. I believe so.

Q. And as I understand your prior testimony, the reason that you believe, fundamentally the reason you believe both Dr. Hirschman and Dr. Davis are in error is because in October of 1998, Nancy Farkas had micrometastases from this disease; correct?

MR. KELLEY: Objection. Go ahead and answer.

A. As I said, she had at least micrometastases if not more than that.

Q. Based on the diagnostic tools that you have contained

in Nancy's medical records, would you agree with me that in October of 1998, she had a negative chest film while in the emergency department of Elyria Memorial Hospital?

A. I think that was November of 1998.

Q. You're right. November 12th of 1998.

A. Yes; she did.

Q. And would you agree with me that she did not have between October of 1998 and March of 1999, excuse me, that she did have between October of 1998 and March of 1999 a stable weight of approximately 150 pounds?

A. You know, I would have to go back and look at those numbers. I don't disagree with you, I just don't remember.

Q. Are you aware of the fact that between October of 1998 and March of 1999 Nancy was examined and treated by two separate physicians other than Dr. Noble, Dr. Bonnie Stamatis, an internal medicine physician, and Dr. Mahajan, a neurologist?

A. I recall that in looking at the record.

Q. Is there anything based on either Dr. Stamatis' or Dr. Mahajan's record that indicates actual metastases either at the brain or the lung?

A. Well, the only way to find these would have been through CT scans or MRI scans. This wouldn't have been detected on physical examination, so there was no way that they would have discovered it.

Q. Based on your review of the records you have in front of you, would you agree that prior to August 2nd of 1999, Nancy Farkas had no documented neurological symptoms?
A. Well, she did have a neurologic exam earlier than that where I believe she had some peripheral findings. She had decreased reflexes in her lower extremities. I believe, if I'm not mistaken, that after a car accident, she had a workup earlier than that. I think it was in the spring. I don't have -- this is just from recollection. I didn't put the dates down, but 1 do think there was some abnormal neurologic findings earlier than the onset of her seizures.
Q. Was there any follow-up for what you're identifying as neurological symptoms in the spring of 1999 done by Dr. Mahajan?
A. I believe he had an initial visit with her for those complaints and didn't schedule a further workup.
Q. Are you aware of any information that's been presented to you to suggest that Nancy, up until early August of 1999, had any decrease in her physical activity?
A. Well, again, if my memories serves me correctly, there were some neurologic problems after this car accident and I imagine that must have affected her physical activity to some degree, though I don't know the details.
Q. Are you aware of the fact or is it consistent with your recollection that this neurological examination by

Dr. Mahajan related to a wrist injury?

A. I think that was his diagnosis; that's correct.

Q. Is there any evidence that you have been presented with to suggest that Nancy had any difficulty performing her day-to-day activities in the spring of 1999?

A. I don't recall such information.

Q. Is there any report that you have been provided to suggest any vision disturbances?

A. No.

Q. Is there any evidence you have been provided to suggest any speech difficulties that Nancy had prior to August of 1999?

A. It's certainly important to clarify that such line of questioning by no means excludes the possibility of metastatic disease.

Q. That wasn't what I asked you, doctor. My question was, is there anything in the record you have in front of you that prior to August of 1999 Nancy Farkas had any speech disturbances?

A. You know, I don't specifically recall that, but I need to tell you, I have made notes on these lengthy records. I don't want to simply make a statement like that to agree with you without actually looking at the records.

Q. Would you agree that as part of the abdominal examination which included deep palpation in October of

1998, that there was no evidence of external or internal masses palpated?

A. Again, I would have to go back to the original records to look. These are general statements that I don't want to just nod and agree with you.

Q. Would you agree on November 12th of 1998, Nancy had normal enzymes?

A. Again, I would have to go back and look at that.

Q. In the event that Nancy had normal liver enzymes on November 12th, 1998, is that fact consistent with the absence of metastases?

A. One certainly could not look at a set of normal liver enzymes and say, therefore, that patient did not have metastatic disease. That's absurd.

Q. My question is, are normal liver enzymes consistent with the absence of metastatic disease?

A. I don't think that you can draw a connection between the two.

Q. Would you agree that on November 23rd of 1998, as part of Nancy's retrograde pyelogram which was negative, which was negative for palpable pelvic mass or tenderness -- I'm sorry.

Would you agree that as part of the November 23rd, 1998 retrograde pyelogram there was a bimanual exam performed? Is that consistent with your understanding?

A. Again, this is a level of detail I would have to go back to the record to look at.

Q. So based on recollection alone, you wouldn't have any dispute that there were no palpable mass as part of that bimanual exam; correct?

A. Again, I can believe you, but I would have to go back to the record to look at that.

Q. Do you know what Nancy Farkas' weight was recorded at on August 2nd of 1999?

A. Regarding her weight, I made a note in my records that she experienced a profound weight loss in the summer of 1999. I didn't record the specific weights on a specific day.

Q. Would you agree that significant weight loss is indicative of met -- can be indicative of metastatic disease?

A. It's generally indicative of far-advanced metastatic disease. It doesn't happen early on. It's really end-stage occurrence when the tumor burden is huge.

Q. As you sit here today, are you aware of what time frame this weight loss occurred in Nancy Farkas?

A. I'd have to go back to the record to chart those specific dates. My recollection is that she had a fairly rapid weight loss over a period of a few months in the summer of 1999, but I don't have access to the specific

weights recorded in the record.

Q. Based on your review of the medical record, are you of the belief that Nancy Farkas had breast cancer?

A. I do not believe that the metastatic disease from which she died was related to her breast cancer. There was a questionably abnormal mammogram and perhaps that was of no significance. Perhaps she had a microscopic area of breast cancer, but it was of no clinical importance in terms of her clinical course.

Q. You would agree that the mammogram that's included in the records you reviewed was a baseline mammogram; correct?

A. I believe she had not had a mammogram in a number of years.

Q. Is it consistent with your recollection that the radiologist's impression of that mammogram was a probable benign finding?

A. I believe that I marked that mammogram, but as I recall -- rather than my recalling, let's look for it.

Q. Feel free to review that.

A. Okay. The impression is there is some asymmetry in the density of the breasts including an area of asymmetry density in the posterior medial left breast. This is not considered suspicious. That is a baseline study to further evaluate the stability of this area of asymmetry. Follow-up mammogram in six months would be recommended.

So if you said to me, you know, could this have been an area of carcinoma in situ, maybe, but it certainly is not relevant to her ultimate demise.

Q. And it would also be fair to say that the findings of this March 31st, 1999 mammogram were not significant to the conclusions that you drew in reviewing these records; correct?

A. Correct.

Q. Have you had an opportunity to see Nancy Farkas' death certificate?

A. I think that it's included in these records.

Q. Did you review the death certificate in conjunction with rendering your opinions in this case?

A. I have it here. Please tell me what your question is about the death.

Q. My question is, did you review the death certificate in conjunction with rendering your opinions in this case?

A. That's a vague question.

Q. Did you have the death certificate available to you for review prior to generating your April 4th, 2000 report?

A. Yes.

Q. Did you review the death certificate prior to rendering your report?

A. I read all these records.

Q. Are you familiar with Dr. James Cunningham?

A. Yes.
Q. Is my understanding correct that he is an oncologist associated with the Ireland Cancer Center?
A. Correct.
Q. Could you -- is Dr. Cunningham a colleague of yours?
A. Yes.
Q. Do you understand that Dr. Cunningham provided care and treatment to Nancy Farkas during her lifetime?
A. Yes.
Q. Are you likewise familiar with or aware of the fact that Dr. Cunningham is the physician who signed Nancy's death certificate?
A. Yes.
Q. Based on your review of the death certificate, would you agree that Dr. Cunningham noted here Nancy's immediate cause of death was cerebral metastases from renal carcinoma?
A. Yes.
Q. And further, that Dr. Cunningham, as part of her -- Nancy's death certificate indicated that those cerebral metastases existed for approximately six months from the time of her death?
A. Well, we don't know what he really meant by that. We don't know whether he meant that they were radiographically apparent for that period of time, whether he meant that the first microscopic cell arose there within six months. I

don't think there's enough information here to really tell us what he meant by that.

Q. But you would agree with me that Dr. Cunningham noted as part of Nancy's death certificate that her brain metastases were present for approximately six months prior to her death; correct?

A. Well, he says -- I mean, if we're going to be very precise, he says, "cerebral metastases from renal carcinoma" and then it says, "approximate interval between onset and death.'' Does that mean between onset of the renal carcinoma? Does it mean onset of the cerebral metastases? If it means onset of cerebral metastases, does it mean pathologic evidence, microscopic presence, radiologic evidence? I think that there are so many ways one could understand this. I don't think it's useful information.

Q. Well, just so that we're both clear, you have in front of you Nancy Farkas' death certificate and you are referring to block 30; correct?

A. Correct.

Q. On line A, it states, "cerebral metastases from renal cell carcinoma"; correct?

A. Correct.

Q. And on the line with cerebral metastases, which he has identified as the immediate cause of death; correct?

A. Correct.

Q. "Approximate interval between onset and death" is noted as six months; correct?

A. Correct.

MR. KELLEY: I object to the individual line reading. It's clearly written as a sentence.

BY MS. DIXON:

Q. And would you agree with me that Nancy's date of death is November 18th of 1999?

A. Correct.

Q. And six months prior to that would leave us at May 18th of 1999 plus or minus; correct?

A. Correct.

Q. And based on your prior testimony, we know that the renal cell carcinoma, as a primary tumor site, would precede the brain metastases; correct?

A. Correct.

Q. Notwithstanding those facts -- excuse me. Have you been informed either by way of review of deposition or has it been orally communicated to you what Dr. Thompson's conclusions are regarding the duration of the brain metastases in Nancy Farkas?

A. All that I know is that Dr. Thompson is serving as a witness on behalf of the Plaintiff, but I haven't seen anything written by him. I don't know -- I know that his

testimony will be favorable to the Plaintiff, but I don't know what his opinions are.

Q. Are you aware of the fact that Dr. Thompson evaluated and treated Nancy Farkas?

A. Yes.

Q. Let me represent to you for the purposes of the next question Dr. Thompson's testimony was, at the time of his deposition, he believed the brain metastases to be present in Nancy Farkas between four and six months prior to her seizure in August of 1999.

MR. CONWAY: Objection.

MR. KELLEY: Objection. I think at the beginning of Dr. Thompson's deposition it was represented that he would offer no opinions in this case regarding standard of care and/or proximate causation and there's never been a report authored by Dr. Thompson on this issue nor is there anything in his medical record which reflects an opinion as to the timing presence of the metastases.

Accordingly, this is a back door way to try to get the standard of care or causation opinions in from Dr. Thompson outside of Local Rule 21.

BY MS. DIXON:

Q. Dr. Levitan, I will represent to you at the time of his deposition in response to questioning by Mr. Conroy --

MR. CONWAY: You might want to get my name correct, Counsel. Conway.

BY MS. DIXON:

Q. -- Conway, Dr. Thompson stated that it was his opinion that brain metastases were present in Nancy Farkas between four and six months prior to her seizure on August 2nd of 1999. You disagree with that; correct?

MR. CONWAY: Objection.

MR. KELLEY: Objection.

MS. PETRELLO: Objection.

A. You know, it's a little hard for me to comment on a deposition that I haven't read, so we're getting into kind of fuzzy territory here. Even the statement you just made, does that mean that he believes that they were not present longer than six months before it happened or just that they were present four to six months beforehand?

Q. I can only represent to you that at the time of his deposition, Dr. Thompson stated that it was his opinion the onset of brain metastases in Nancy Farkas was between four and six months prior to her seizure on August 2nd of 1999.

MR. CONWAY: Objection.

BY MS. DIXON:

Q. Do you disagree with that statement?

MR. KELLEY: Objection.

A. I would have to know more information. I would say,

well, are we talking about radiographic evidence? Are we talking about when the first microscopic metastatic cell arrived in the brain? Those are very different issues.

Q. Assuming that at the time of trial both Dr. Cunningham and Dr. Thompson testify that brain metastases, the onset of brain metastases in Nancy Farkas was six months prior to her death, you would disagree with that statement; correct?

MR. KELLEY: Objection to both of them testifying. Now we have two individuals who you are representing are going to offer opinions that haven't written reports. You can answer, if it's possible, to that question.

A. So you're saying that if doctors X and Y, regardless of who they are, testify that six months and a day prior to her death there was not a single microscopic tumor cell from renal cancer present in her brain, would I agree with that? The answer is absolutely not.

Q. I think my question was, if Dr. Thompson and Dr. Cunningham testified at the time of trial that onset of brain metastases was six months prior to the time of death, would you disagree with that?

MR. KELLEY: Objection.

A. I think I have explained my answer. One needs to use precise language and have a clear explanation of what one means by the "onset of brain metastases" and before defining

the question more carefully, I can't give you a better answer than that.

Q. Doctor, do you agree as a general medical principle a physician has an obligation to rule out the most serious medical problem?

A. I'm not sure what you're asking.

Q. If a physician is presented with two separate potential diagnoses of a patient, would you agree that that physician has an obligation to rule out the most serious problem first?

MR. KELLEY: Objection. The question is vague. It doesn't contain timing potential parameters to it based upon the individual two problems.

A. I'm not sure what you're asking.

Q. Would you agree that in October of 1998, Nancy's most serious medical problem was not a kidney stone?

MR. KELLEY: Objection. Lack of time frame.

MS. DIXON: I think I said in October of 1998.

MR. KELLEY: That's not the time frame I'm talking about in my objection. My objection is continued, for the record.

A. In October of 1998, there were a number of possible explanations for her blood in the urine and flank pain, and

it's my opinion, as I have explained, that in a methodical and reasonable fashion, Dr. Noble laid out in his mind a plan for evaluating and identifying the source of bleeding and I believe I have also explained that the schedule that he selected for this in no way compromised her outcome.

Q. So in layman's terms, Nancy was going to die anyway, so even if Dr. Noble missed the diagnosis, it really didn't matter?

MR. KELLEY: Objection to the phraseology.

A. I would hate to be quoted as using that language because that's not a way that I would express information.

Q. Would you agree that that may be the way regular people receive that information?

MR. KELLEY: Objection. Ask regular people.

BY MS. DIXON:

Q. Lay people.

MR. KELLEY: Objection. Ask lay people.

A. I'm not sure what you are asking me.

Q. Well, as I understand your opinions in this case, and correct me if I'm wrong, first of all, you don't believe Dr. Noble breached the relevant standard of care in not diagnosing renal cell carcinoma; correct?

A. Well, as I have explained, Dr. Noble had a plan that would have led to the diagnosis of renal cancer that was not completed because she failed to follow up with him, but he certainly would have achieved a diagnosis if she had.

Q. If it turned out that it was Dr. Noble who informed Nancy Farkas she did not need to return to his office unless she had additional flank pain or additional hematuria, would you then be critical of the care that he provided to Nancy during her lifetime?

A. You're asking if he had no intention of actually following through with a CT scan to evaluate this abnormality on IVP with the kidney?

Q. Yes.

A. That would have been an omission.

Q. And would you agree with me the only evidence you have in front of you that Dr. Noble did plan on performing a CT scan was his testimony at the time of deposition?

A. Well, that plus the fact that he scheduled follow-up for -- actually, he scheduled follow-up for this patient for January 15th. That's documented in the handwritten note. He documented in his typed note that he was scheduling follow-up in one month.

When he spoke with the patient's sister on December 9th, he stressed the importance of continuing to work up this problem, and even when he passed the records

onto what he believed was another physician in Oklahoma in August of 1999, he stressed the importance of conscientious follow-up.

Q. Actually, what Dr. Noble purported in -- stressed in September of 1999 was the need for additional metabolic workup; correct?

MR. KELLEY: And follow up with a urologist.

BY MS. DIXON:

Q. Through that urologist; correct?

MR. KELLEY: Objection to the phrase "through."

A. Correct.

Q. Now, Dr. Levitan --

A. Let me be sure because I am agreeing in part with Mr. Kelley and in part with you. What he agreed, for the record, that he agreed -- pardon me. What he stressed was the importance of continued follow-up and workup of this patient.

Q. Based on your last answer, is there any suggestion, assuming Dr. Noble did, in fact, schedule an additional appointment January 15th of '99, is there any indication in the record as to what would transpire at that office visit?

A. No.

Q. Was there any suggestion in his --

A. Well, he says plan stone workup tests. I believe something like that. There was terminology that he was planning additional tests.

Q. There was nothing that mentioned CT scan; correct?

A. Correct.

Q. And in the portion of Dr. Noble's chart that refers to Miss Farkas' following up with a physician in Oklahoma, would you agree with me that there is no suggestion as part of that -- in that part of the record about renal cell carcinoma?

A. He says, okay, "Please remind her she never completed metabolic stone testing! She needs to see a urologist in Oklahoma." So I take that to mean that he is emphatically recommending that she has urologic follow-up.

Q. Is there any discussion in the note that you just referred to, or the portion of Dr. Noble's records that you just referred to, that indicates the need for a CT scan?

A. It doesn't specifically say that.

Q. You have certainly given me the sense in the last two hours you see an extraordinary number of patients in your practice. Is that fair?

A. I don't know what "extraordinary" is.

Q. You stated earlier you saw 12 patients --

A. I see a lot of patients.

Q. And that I'm certain at some point during your career

as a medical doctor you have had instances where you have encountered a noncompliant patient; correct?

A. Correct.

Q. Have you likewise encountered instances where a patient has unilaterally discontinued treatment with your office?

A. Yes.

Q. In either of those scenarios, whether it's a patient who disregards medical advice or discontinues treatment, have any of those situations been in the face of a potentially life-threatening condition?

A. Most of the patients that I take care of have life-threatening conditions.

Q. Can you describe for me in the face of a patient who either disregards your medical advice or discontinues treatment unilaterally with a potentially life-threatening condition what steps you take to notify the patient of the risks associated with those decisions?

MR. KELLEY: Objection. You can answer.

A. Right. I mean, I think that's a very general question. I think it depends upon the clinical situation.

Q. Let me ask you this, doctor, would it be fair to say in instances where a patient either unilaterally discontinues treatment or disregards your advice in the face

of a potentially life-threatening condition that you would take some affirmative steps to make clear to that patient what the risks of that decision were?

A. This is a very general line of questioning and I think it really depends upon the situation. It depends upon whether I know the patient has cancer or not. It depends upon the level of suspicion. It depends on where and how the patient is following up. I think there are too many variables for me to generalize.

Q. If you believed that patient may have cancer, is there a situation you can envision where you would do absolutely nothing in the face of a unilateral discontinuation of treatment?

MR. KELLEY: Objection.

A. I don't know how to answer your question.

Q. Would you call the patient?

A. I think it depends on the situation and whether I feel that that patient is going elsewhere for care. Also, physicians see a lot of patients in their practice, and I think that the patient has to take some responsibility for following up with recommended workup. I think that it's not reasonable to expect that a physician who has articulated the need for follow-up would chase a patient.

Q. I asked you earlier that if the evidence in this case unfolded that Dr. Noble told Miss Farkas she did not need to

return for additional care or treatment unless she had recurrent flank pain or recurrent hematuria, you would be critical of his treatment; correct?

A. Yes.

MR. KELLEY: Objection. Asked and answered.

BY MS. DIXON:

Q. In the event that that was the case, that Dr. Noble is the one who suggested there was no need for additional care and treatment, would you likewise be critical of him if he had attempted to shift the blame of that situation to the patient?

MR. KELLEY: This is getting rather theoretical. I think that's more of a jury question. You can answer if possible.

A. You're losing me here.

Q. You have told me that you would be critical if Dr. Noble was the one who discontinued treatment with Miss Farkas prior to further evaluating her cyst or mass; correct?

A. Correct.

Q. My question is, if those were the facts that laid out in front of you and Dr. Noble had set forth facts in this case to lead one to believe the patient had discontinued treatment as opposed to him, would you be critical or

disappointed in him?

MR. KELLEY: Objection to "disappointed in him" as having any relevance to this case. If he has a criticism, you can answer.

A. Right. Right. I think this is a very vague question. I don't know how to respond to that.

Q. So you don't know how to respond to whether or not you would be critical of a physician who fabricated a story to protect himself from liability?

A. In other words, if you said to me do I think that X, Y or Z is within the standard of care of community practice of medicine and you are asking about certain testing procedures, I'm comfortable with that. But this seems to be outside of the realm of the kinds of standard of care questions I'm accustomed to answering.

Q. Do you believe that Dr. Noble provided Nancy Farkas the best opportunity for care and treatment as it related to her renal cell carcinoma?

A. As I said, I believe that the plan Dr. Noble followed or intended to follow had the patient returned to him was entirely reasonable and would have afforded her the best possible outcome with her cancer.

Q. But notwithstanding that, would you still expect her to be dead today?

A. Correct.

Q. So even if Nancy had followed up as Dr. Noble alleges he instructed her to do, it's your position that as we sit here today, she would not be alive?

A. Correct.

MS. PETRELLO: Asked and answered.

MS. DIXON: I'd like to take a minute. Let's go off.

(Thereupon, a recess was taken.)

THE VIDEOGRAPHER: Back on.

BY MS. DIXON:

Q. Doctor, as part of the records you have been provided, do you have Dr. Cunningham's records from the Ireland Cancer Center?

A. I have them in front of me.

Q. Contained in there is a three-page report dated September 21st of 1999.

A. I have it.

Q. I would ask you to turn to the second page of that report, the last paragraph, about halfway through the second paragraph, the sentence that begins "we noted."

A. "We noted, for example, the relatively low volume of disease that Mrs. Farkas has as including the favorable location of pulmonary metastases within the chest both of which would tend to indicate likely responsiveness to immunologic treatment. In that regard, we discussed a

program of combined immunotherapy and low dose subcutaneous interleukin-2 and concomitant interferon therapy to be given on an outpatient basis on a once daily basis for five days per week and then repeated on a weekly basis for up to three consecutive weeks in four-week cycle," et cetera, et cetera.

Q. Okay. As it relates to the statement, "The relatively low volume of disease that Mrs. Farkas has," is that relating to her brain metastases?

A. Well, I can tell you what my association to this -- my understanding of this statement would be. This is conjecture on my part. Acknowledging that, as medical oncologists, we try to balance providing a patient with truth about their disease and also some measure of hope, and I could imagine sitting down with a patient who has a very serious disease Who's about to start chemotherapy and trying to project the best possible face of that disease in order to give the patient some hope in initiating treatment.

And I think that that is what Dr. Cunningham is doing here by saying, look, you don't have liver metastases, you don't have bone metastases. You know, we can radiate your brain, and lung lesions are often responsive, never cured, but responsive to interleukin-2, and I think that this is a reflection of his very humane approach to that patient. I don't think this is a statement to describe the biologic nature or the natural history of this cancer.

Q. Dr. Levitan, the document you are referring to or we're discussing at this point, this is not a document that was for the benefit of Nancy Farkas, is it? This is a between medical professionals document?

A. I think he's describing the conversation he had with the patient.

Q. Let's take a moment and refer specifically to the phrase, "the relatively low volume of disease that Mrs. Farkas has." Is that relating to her brain metastases?

A. Well, I don't really know what it's relating to.

Q. Is there any suggestion that this document was for the benefit of anybody other than Dr. Cunningham, Dr. Stamatis, Dr. Thompson and to be part of Dr. Cunningham's record?

A. I believe that what he is reflecting is the content of his discussion with the patient, and I think that it is of use to those other physicians because it will help them to use a similar approach in discussing this illness with the patient.

Q. Do you disagree, assuming that that phrase related to Nancy Farkas' brain metastases on September 21, 1999, do you disagree with that description that she had a relatively low volume of disease?

A. Well, you know, it's one of these vague terms. It sort of goes in the same basket with aggressive and things like that. This patient had a lot of cancer. This patient

had lost 35 pounds. This patient had lung mets, brain mets and died within weeks of this, within a few short weeks of this encounter, regardless of how Dr. Cunningham described her tumor volume and regardless of whether this is, as I believe, a description of a humane way of presenting this to the patient or not, this patient died a few weeks later. This was a lethal tumor burden at that point in time.

Q. My question is, do you disagree with Dr. Cunningham's description of Nancy's brain metastases as relatively low volume of disease?

MR. KELLEY: Objection.

BY MS. DIXON:

Q. Is it your position that in a patient with micrometastases of the brain, there is no meaningful treatment to prolong that patient's life?

A. I think it's a vague statement that I couldn't either agree or disagree with.

Q. I don't know what that means.

A. If you could ask that question in reference to Mrs. Farkas, it would be easier for me to answer than as opposed to a theoretical question.

Q. I would like to ask you the more general question first, just as stated.

MS DIXON: Can you read it back, please?

(Record read as follows:)

THE NOTARY: "Question: Is it your position that in a patient with micrometastases of the brain, there is no meaningful treatment to prolong that patient's life?"

A. I think it depends on the clinical situation.

Q. And would you agree that the physicians that actually evaluated Miss Farkas in a clinical setting would be in a better position to comment on whether or not there was meaningful treatment available to her to control her disease and when?

A. Well, as the saying goes, hindsight is always 20/20. In fact, now that we can look back, we can make much more accurate conclusions than could her physicians at any point in time without the benefit of all the information we have today.

Q. So it's your position that you, as the hindsight reviewer, are in a better position to comment on whether or not there was meaningful treatment available to Miss Farkas from October '98 forward?

A. Yes.

Q. Other than the opinions that you set forth in your report dated April 4th of 2000, are there any other opinions you expect to testify about at the time of trial?

A. Let me answer you this way, I have tried very hard to

convey all those ideas that I think are important either in this document dated April 4th or in response to your questions today. That's a potentially dangerous question because I imagine that something could come out at the trial in response to your question and then you could say to me, well you didn't tell me that on June 20th in good faith. I have tried to express all my opinions today, though I don't know what would be elicited by additional questions you may ask at a later date.

MS. DIXON: I thank you for your time. I don't have any further questions.

MR. KELLEY: Colleen, do you have any questions.

MS. PETRELLO: No; I don't.

MR. KELLEY: He will read

- - -

(Thereupon, the deposition was concluded at 12:00 p.m. and signature was not waived.)

SIGNATURE PAGE

_____
Nathan Levitan, M.D.

I certify that this deposition was signed in my presence by Nathan Levitan, M.D. on this_____day of _____, 2000.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office in this City of_____, County of_____, on this _____ day of_____, 2000.

_____
Notary Public
My commission expires:

NANCY FARKAS vs. CLEVELAND CLINIC FOUNDATION, et al.
Case Number 393101 Judge McCafferty
Deposition Date Tuesday, June 20, 2000

I, NATHAN LEVITAN, M.D., wish to make the following changes:

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County of Cuyahoga)

CERTIFICATE

I, Denise C. Winter, a Notary Public within and for the State aforesaid, duly commissioned and qualified, do hereby certify that the above-named witness NATHAN LEVITAN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid, and that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of any of the parties hereto, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand

this 21st day of Edit, 2000.

_____
Denise C. Winter
Notary Public

My commission expires March 3, 2001.

Atty Kelly

Farber v. CCF

Dr Noble - GU
Markarian - Neurol.
O'Lanyan - radiol
Thompson - XRT

additional Records - Dep. Dr Noble

10/98 - flank pain/hematuria
IVP dilated Ⓡ ureter + Ⓡ hydronephrosis
KUB ⊖
11/98 - CAR ⊖
cysto + retrograde ⊖
12/98 Pelvic Echo ⊖
8/99 Sz → HdCT - mult lesions largest 10cm / const sx - 30# wt loss
(5)
MRI Hd - mult lesions largest 12cm /
CXCT - mult nodules largest 12cm + adenopathy
abd CT - 5cm renal mass
11/99 - Ms. Farber died

Visits: 10/26/98 - gen tension: review IVP;
11/12/98 - culture sent
11/23/98 - cysto + Ⓡ stent/retrograde
12/7/98 - notes nl pelvic echo → f/up 1mo 1/15/99
12/9/98 - P.C. - delay 2° urine until p X-mas
8/99 - Sister picks up records

x-rays, and, if clinically indicated, isotopic studies. Clinical staging may also include laparotomy and biopsy of distant sites.

Pathologic Staging. Histologic examination and confirmation of extent is recommended. Resection of the primary tumor, kidney, Gerota's fascia, perinephric fat, renal vein, and appropriate lymph nodes is recommended. Laterality does not affect the N classification.

DEFINITION OF TNM

Primary Tumor (T)

TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
T1	Tumor 7 cm or less in greatest dimension limited to the kidney
T2	Tumor more than 7 cm in greatest dimension limited to the kidney
T3	Tumor extends into major veins or invades the adrenal gland or perinephric tissues, but not beyond Gerota's fascia
T3a	Tumor invades the adrenal gland or perinephric tissues but not beyond Gerota's fascia
T3b	Tumor grossly extends into the renal vein(s) or vena cava below the diaphragm
T3c	Tumor grossly extends into the renal vein(s) or vena cava above the diaphragm
T4	Tumor invades beyond Gerota's fascia

Regional Lymph Nodes (N)*

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Metastases in a single regional lymph node
N2	Metastasis in more than one regional lymph node

**Note:* Laterality does not affect the N classification.

Distant Metastasis (M)

MX	Distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis

STAGE GROUPING

Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T1	N1	M0
	T2	N1	M0
	T3a	N0	M0
	T3a	N1	M0
	T3b	N0	M0
	T3b	N1	M0
	T3c	N0	M0
	T3c	N1	M0
Stage IV	T4	N0	M0
	T4	N1	M0
	Any T	N2	M0
	Any T	Any N	M1

HISTOPATHOLOGIC TYPE

The predominant cancer is adenocarcinoma; subtypes are clear-cell and granular-cell carcinoma. A grading system as below is recommended when feasible. Sarcomas and adenomas are not included. The histopathologic types are:

Renal cell carcinoma
Adenocarcinoma
Renal papillary adenocarcinoma
Tubular carcinoma
Granular cell carcinoma
Clear cell carcinoma (hypernephroma)

HISTOPATHOLOGIC GRADE (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3-4	Poorly differentiaced or undifferentiated

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April 4,2000

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Re: Nancy J. Farkas v. The Cleveland Clinic Foundation, et al.
Cuyahoga County Court of Common Pleas Case No. 393101
Reminger File No. 2100-10-41354-99

Dear Mr. Kelly:

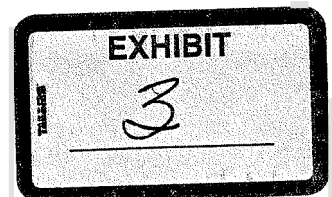
I am writing to you in follow-up of ourrecent telephone conversation. I nave reviewe available medical records pertaining to the care of Ms. Farkas, and I have formulated a number of opinions in this regard.

I have reviewed the following records:

- Office records of Dr. Noble
- EMH Regional Medical Center inpatient and emergency records
- Radiology reports from EMH Regional Medical Center
- Report of Richard J. Hirschman, M.D.
- Report of Joseph Edward Davis, M.D.

Key dates and events can be summarized as follows:

- On 10/20/98 Ms. Farkas was evaluated at EMH for flank pain and hematuria. IVP was performed and was read by Dr. Ocampo. The interpretation read as follows: "...Obstructive uropathy at the level of the distal right ureter. etiology undetermined, which could be secondary to a non-opaque or faintly opaque calculus. Retrograde pyelogram would be helpful for further evaluation...Persistent filling defect right in the lower lateral border of the kidney. probably represents a cyst or a mass...CT scan or renal conogram would be helpful for further evaluation."



- Dr. Noble evaluated Ms. Farkas on 10/26/98, 11/12/98, and 12/7/98. His work-up included a cystoscopy and right retrograde pyelogram on 11/23/98. This study revealed no evidence of a ureteral calculus. The urethra, bladder, right ureter, and right renal collecting system appeared normal. Other studies included an unremarkable chest x-ray on 11/22/98, an unremarkable KUB on 10/27/98, and a pelvic sonogram on 12/7/98 that showed only uterine fibroids. The patient did not return to Dr. Noble following the 12/7/98 visit.

- On 8/2/99 Ms. Farkas was hospitalized following a grand mal seizure at home. CT scan of the brain revealed multiple enhancing lesions involving both cerebral hemispheres. Chest x-ray on that day was unremarkable. MRI of the brain performed on 8/3/99 revealed five metastatic lesions, the largest of which measured 1.2 cm. CT scan of the chest performed on 8/3/99 revealed multiple pulmonary nodules, the largest of which measured 1.4 cm. Also noted were hiiar adenopathy and a 5 cm right renal mass. CT guided biopsy of the renal mass revealed renal cell carcinoma, clear cell type.

- Though I do not have detailed records in this regard, I understand that she was treated with Dilantin and Decadron, and that she received brain irradiation. Her condition continued to deteriorate. and she expired on 11/18/99.

My opinions concerning this case include the following:

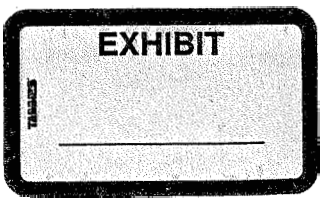
1. In retrospect, the hematuria and flank pain that Ms. Farkas experienced beginning in late October of 1998 were likely due to a renal carcinoma that was subsequently diagnosed in early August of 1999.

2. It is likely that the filling defect visualized in the inferior aspect of the right kidney on IVP in late October of 1998 represented the renal carcinoma.

3. I do not know whether Dr. Noble intended to perform additional studies to complete the work-up for hematuria following the 12/7/98 visit. However, if the patient had returned to Dr. Noble, and if Dr. Noble had obtained a CT scan or ultrasound of the right kidney, it is likely that the renal mass would have been visible at that time. If this work-up had been completed, it is likely that Ms. Farkas' renal cancer would have been diagnosed in December of 1998 or January of 1999, six to seven months earlier than the actual date of diagnosis.

4. It is well known that renal cancer is an extremely slow growing cancer (especially clear cell type) and that most renal cancers are many years old at the time of diagnosis.

5. The survival statistics for patients with renal cancer are remarkable in that the risk of dying of renal cancer within five years following surgical resection is



approximately 35% for patients with stage I tumors and 50% for patients with stage 11 tumors. At the ten-year follow-up point, the risk of death from renal cancer is **45%** for stage I and 63% for stage II. These survival statistics exhibit a key feature of the natural history of this disease: renal cancer cells tend to metastasize to distant sites in the body early in the growth period of the tumor, though metastatic disease may not become clinically evident until many years later.

6. As noted above, if an abdominal CT scan or a renal ultrasound had been performed in December of 1998 or **January** of 1999, it is likely that Ms. Farkas' renal cancer would have been diagnosed at that time. However, it is my opinion as a medical oncologist that the cancer had already metastasized to lung and brain as of December of 1998 or **January** of 1999.

7. Accordingly, a diagnosis of renal cancer six to seven months prior to the actual date of diagnosis would not have altered the patient's prognosis. She would still have developed symptomatic brain metastases, and she would still have died from widely metastatic disease.

Please let me know if I can be of further assistance.

Sincerely,

Nathan Levitan, M.D.

EXHIBIT